

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9770 CERTIFICATE OF DEATH

09754

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY MD		c. LENGTH OF STAY IN 1b 64 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) PENINSULA GERENAL HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCESS ANNE MD RTI.	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First DENNIS Middle L. Last BAILEY		4. DATE OF DEATH Month 9 Day 12 Year 1956	
5. SEX male	6. COLOR OR RACE col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/14/1892
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (State or foreign country) MT VERNON MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM BAILEY		14. MOTHER'S MAIDEN NAME MARY BLOODWARTH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 220-10-8576	
17. INFORMANT MATILDA BAILEY PRINCESS ANNE MD RTI.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 332x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension Arteriosclerosis DUE TO 3 years or more (c) Left Ventricular Hypertrophy INTERVAL BETWEEN ONSET AND DEATH 3 years or more			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Salisbury Wicomico Md	
21. I certify that I attended the deceased from Sept 12, 1956 , to Sept 12, 1956 , that I last saw the deceased alive on Sept 12, 1956 , and that death occurred at 3:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. Herbert Sembly M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Salisbury Md	
PHYSICIAN'S NAME (Type) G. Herbert Sembly		400 E. Church St. Salisbury Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/16/56	22c. NAME OF CEMETERY OR CREMATORY ST PAUL	22d. LOCATION (City, town, or county) (State) MT VERNON MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE William H. Janciga		24a. REC'D BY REGISTRAR DATE 9-14-56	
24b. REGISTRAR'S SIGNATURE Mary W. Holloway			

CERTIFICATE OF DEATH

1770

BUREAU V. E.

SEP 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9813
CERTIFICATE OF DEATH

09755
337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hebron		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.#		d. STREET ADDRESS R.D.#	
3. NAME OF DECEASED (Type or print) First ELSIE Middle MARY Last BAILEY		4. DATE OF DEATH Month SEPT. Day 29th Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 28, 1896
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) R.D.# Girdletree, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Alonzo F. Carter		14. MOTHER'S MAIDEN NAME Cora Connelly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mr. Carl M. Bailey (Husband)		Address R.D.# Rural Hebron, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) Chronic Myocarditis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 yr 6 yr			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 15, 1956 , to Sept. 27, 1956 , that I last saw the deceased alive on Sept 27, 1956 , and that death occurred at 10:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Sept. 30 1956			
ACTUAL SIGNATURE Dr. Vernon E. Spitznagle M.D.		PHYSICIAN'S NAME (Type) Dr. Vernon E. Spitznagle M.D. Mardela Springs, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 2, 1956	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR 3 1956	
24b. REGISTRAR'S SIGNATURE Nary H. Holloway			

CERTIFICATE OF DEATH

STATE OF MARYLAND - DEPARTMENT OF HEALTH - BALTIMORE 10

1956

Page One

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 68		4. DATE OF BIRTH 1888		5. PLACE OF BIRTH Maryland	
6. OCCUPATION Retired		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1915		9. PLACE OF MARRIAGE Maryland		10. NAME OF SPouse Mary H. Harris	
11. DATE OF DEATH 1956		12. PLACE OF DEATH Home		13. CAUSE OF DEATH Heart Disease		14. MANNER OF DEATH Natural		15. SIGNATURE OF PHYSICIAN J. H. Harris	
16. SIGNATURE OF DECEASED J. H. Harris		17. SIGNATURE OF NEXT OF KIN Mary H. Harris		18. SIGNATURE OF WITNESSES J. H. Harris, Mary H. Harris		19. SIGNATURE OF REGISTRAR J. H. Harris		20. SIGNATURE OF CLERK J. H. Harris	

BUREAU V. 3

OCT 3 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9771

CERTIFICATE OF DEATH

09756

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>1 1/2</u> years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>Hurlock</u>			
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Henry</u> Last <u>Bradley</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>14</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20, 1866</u>	9. AGE (In years last birthday) <u>90</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>John Bradley</u>			
14. MOTHER'S MAIDEN NAME <u>Sara Walker</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unk.</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial insufficiency</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>Mar. 10</u> , 19 <u>55</u> , to <u>Sept. 14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept. 14</u> , 19 <u>56</u> , and that death occurred at <u>1:05 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u>				DATE SIGNED <u>9/14/56</u>			
ACTUAL SIGNATURE <u>Andres Grisolia</u> M.D.				PHYSICIAN'S NAME (Type) <u>Andres Grisolia, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Sept. 16, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Vienna Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Vienna, Maryland</u>				22e. (State) <u> </u>		22f. (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u>				42a. REC'D BY REGISTRAR DATE <u>9-18-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
JAMES H. HARRIS		MALE		45		JAN 15 1910		BALTIMORE, MD.		LABORER	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		OCCUPATION OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		JAN 15 1935		BALTIMORE, MD.		LABORER		JAN 15 1956		BALTIMORE, MD.	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH	
HEART DISEASE		NATURAL		BALTIMORE, MD.		JAN 15 1956		BALTIMORE, MD.		JAN 15 1956	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF SIGNATURE	
JAMES H. HARRIS		JAN 15 1956		BALTIMORE, MD.		JAN 15 1956		BALTIMORE, MD.		JAN 15 1956	
SIGNATURE OF REGISTRAR		DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF SIGNATURE	
JAMES H. HARRIS		JAN 15 1956		BALTIMORE, MD.		JAN 15 1956		BALTIMORE, MD.		JAN 15 1956	

RECEIVED
SEP 19 1956
BUREAU K. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, See: Birth Cert. et

CERTIFICATE OF DEATH

9772

69757

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>Route #5</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Brittingham</u>				4. DATE OF DEATH Month Day Year <u>September 5 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 4, 1956</u>	9. AGE (In years lost birthday) yrs. <u>5</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>EARL BRITTINGHAM</u>				14. MOTHER'S MAIDEN NAME <u>Betty O'Live Gale</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>CARRIE GALE-GRAND MOTHER</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>761.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> (c) <u>Placenta Previa & Fetal Anoxia</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 5, 1956</u> , to <u>Sept 5, 1956</u> , that I last saw the deceased alive on <u>Sept. 5, 1956</u> , and that death occurred at <u>3:20 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William C. Morgan</u> M.D. <u>Salisbury, Md</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>9/6/56</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>9-7-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Whitehaven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Whitehaven, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Carrie Gale</u> ADDRESS <u>Salisbury Md</u>				24a. REC'D BY REGISTRAR DATE <u>9-7-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W Holloway</u>	

2082192XVI

CERTIFICATE OF DEATH

Ark. Stat. Sec. 44-101

<p>1. NAME OF DECEASED [Faint text, possibly "WILLIAM"]</p>		<p>2. SEX [Faint text, possibly "MALE"]</p>	
<p>3. AGE [Faint text, possibly "45"]</p>		<p>4. DATE OF DEATH [Faint text, possibly "SEP 10 1956"]</p>	
<p>5. PLACE OF DEATH [Faint text, possibly "HOME"]</p>		<p>6. CAUSE OF DEATH [Faint text, possibly "HEART DISEASE"]</p>	
<p>7. MEDICAL HISTORY [Faint text, possibly "HYPERTENSION"]</p>		<p>8. OCCUPATION [Faint text, possibly "FARMER"]</p>	
<p>9. SIGNATURE OF PHYSICIAN [Faint signature]</p>		<p>10. SIGNATURE OF REGISTRAR [Faint signature]</p>	

BUREAU V. S.

SEP 10 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9773 CERTIFICATE OF DEATH

19758

33✓

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>6 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>Park Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Gladys</u> <u>Rebecca</u> <u>Campbell</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>9</u> - <u>24</u> - <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>A.A.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>8-10-1910</u>	9. AGE last birthday <u>46</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>14</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chicken Plant</u>		11. BIRTHPLACE (State or foreign country) <u>Portsmouth, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mack Cambell</u>				14. MOTHER'S MAIDEN NAME <u>Emma</u> <u>Campbell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>231-34-3784</u>		17. INFORMANT & ADDRESS <u>Virginia Branch, Fruitland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>443X Hypertensive Cardiovascular</u>						INTERVAL BETWEEN ONSET AND DEATH <u>contaminated</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 9-24, 1956, and that death occurred at..... P.M., from the causes and on the date stated above. SIGNATURE <u>William B. Ellis Jr.</u> M.D. ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>9-28-56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-27-56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>		LOCATION (City, town, or county) (State) <u>Fruitland, Wicomico Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart</u>		ADDRESS <u>Funeral Home, Salisbury, Md.</u>	

OCT 1 1956

1956 OCT 1

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9774
CERTIFICATE OF DEATH

09759

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 314 Race St		d. STREET ADDRESS 314 Race St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MYRTLE Middle ELIZABETH Last CAMPBELL		4. DATE OF DEATH Month SEPT. Day 26 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 10, 1905
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) R.D.# Hebron Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Nathan Coulbourn		14. MOTHER'S MAIDEN NAME Elizabeth Foskey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. James H. Campbell (Husband) Address Salisbury, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Dilatation DUE TO Essential Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 9 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/26 , 19 56 , to 9/26 , 19 56 , that I last saw the deceased alive on 9/26 , 19 56 , and that death occurred at 8:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE W. H. B. Smith M.D. Medical Center		Sept. 28 1956	
PHYSICIAN'S NAME (Type) Dr. William Smith M.D. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 30 1956	
22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Walston, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD. ADDRESS		24a. REC'D BY REGISTRAR CT 1 1956	
		24b. REGISTRAR'S SIGNATURE Mary J. Holloway	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

9775

097360

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN lb <u>life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Catherine Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Julius</u> Middle <u>Church</u> Last <u>Church</u>				4. DATE OF DEATH Month <u>9</u> Day <u>12</u> Year <u>19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1906</u>		9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>12</u> Hours <u>56</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>chef</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oaks Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Quantico, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John Church</u>				14. MOTHER'S MAIDEN NAME <u>Ella Birchhead</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-07-9392</u>		17. INFORMANT <u>John Church, 526 W. Isabella St. Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardio-vascular disease</u> DUE TO (c) <u>Sudden</u> Years							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-15-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Quantico Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart Funeral Home, Salisbury, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 17 1956</u>			
				24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

SEP 14 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9776

CERTIFICATE OF DEATH

09761

Reg. Dist. No.

382

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Riverside Nursing Home		d. STREET ADDRESS 716 E. Church St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DAVID Middle J Last CLARK		4. DATE OF DEATH Month SEPTEMBER Day 14 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 19, 1873
9. AGE (In years last birthday) 82		IF UNDER 1 YEAR Months 9 Days 25	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store	11. BIRTHPLACE (State or foreign country) Powellville, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Noah T. Clark		14. MOTHER'S MAIDEN NAME Fanny Adkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mr. John G. Howie (Son-in-Law) Address 824 E. Church St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A. 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10-2-53 , 19 53 , to 9-14 , 19 56 , that I last saw the deceased alive on 9-14 , 19 56 , and that death occurred at 9:55 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE A. C. Mitchell		ADDRESS (Street, city or town, state) Maryland Ave. (Office) Sept. 17 1956	
DATE SIGNED Sept. 17 1956			
PHYSICIAN'S NAME (Type) Dr. Andrew C. Mitchell M.D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 17, 1956	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24. REC'D BY REGISTRAR SEP 18 1956 24b. REGISTRAR'S SIGNATURE Mary T. Holloway	

2010 12 1

BUREAU V. 8.

SEP 18 1956

RECEIVED

1

9777 CERTIFICATE OF DEATH

Reg. Dist. No. 332

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The attending physician or hospital may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>				TOWN <u>SALISBURY</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA General Hospital</u>				STREET ADDRESS (If rural give location) <u>408 S. PARK DRIVE.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last) <u>COOPER,</u>				<u>September 25 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
<u>MALE</u>	<u>white</u>						<u>1 15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>Maryland</u>			
13. FATHER'S NAME <u>Russell Carroll Cooper</u>				14. MOTHER'S MAIDEN NAME <u>Phyllis Amelia Marshall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
7615 IMMEDIATE CAUSE (A) <u>Prematurity (gestation 22 Wks)</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 1/4 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>approx - 1 lb 15 oz</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Premature Separation placenta (maternal)</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> et work Not while <input type="checkbox"/> et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>25 Sept. 1956</u> , to <u>25 Sept. 1956</u> , that I last saw the deceased alive on <u>25 Sept. 1956</u> , and that death occurred at <u>11:30</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>R. W. Samuels Jr.</u>				ADDRESS (Street, city, town, state) <u>926 N. Division St Salisbury</u>			
DATE <u>9-26-56</u>				DATE SIGNED <u>9-26-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>cremation</u>		<u>9/26/56</u>		<u>Peninsula General Hospital</u>		<u>Salisbury Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>9-26-56</u>		<u>Mary W. Holliday</u>		<u>Peninsula General Hospital</u>			

2082262XV0

CERTIFICATE OF DEATH

Form 100-100-100

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. DATE OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF JUDGE

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF CORONER

20. SIGNATURE OF JURY

21. SIGNATURE OF COURT

22. SIGNATURE OF STATE

23. SIGNATURE OF COUNTY

24. SIGNATURE OF CITY

25. SIGNATURE OF TOWNSHIP

26. SIGNATURE OF PARISH

27. SIGNATURE OF VILLAGE

28. SIGNATURE OF HAMLET

29. SIGNATURE OF CENSUS TRACT

30. SIGNATURE OF BLOCK

31. SIGNATURE OF HOUSE

32. SIGNATURE OF ROOM

33. SIGNATURE OF BED

34. SIGNATURE OF CHAIR

35. SIGNATURE OF TABLE

36. SIGNATURE OF CUPBOARD

37. SIGNATURE OF STOVE

38. SIGNATURE OF REFRIG.

39. SIGNATURE OF W.C.

40. SIGNATURE OF BATH

41. SIGNATURE OF HALL

42. SIGNATURE OF PORCH

43. SIGNATURE OF GARAGE

44. SIGNATURE OF DRIVE

45. SIGNATURE OF FENCE

46. SIGNATURE OF GARDEN

47. SIGNATURE OF YARD

48. SIGNATURE OF WALK

49. SIGNATURE OF PATH

50. SIGNATURE OF BRIDGE

51. SIGNATURE OF TUNNEL

52. SIGNATURE OF CANYON

53. SIGNATURE OF MOUNTAIN

54. SIGNATURE OF HILL

55. SIGNATURE OF VALLEY

56. SIGNATURE OF PLAIN

57. SIGNATURE OF DESERT

58. SIGNATURE OF TUNDRA

59. SIGNATURE OF STEPPE

60. SIGNATURE OF PRairie

61. SIGNATURE OF PRAIRIE

62. SIGNATURE OF PRAIRIE

63. SIGNATURE OF PRAIRIE

64. SIGNATURE OF PRAIRIE

65. SIGNATURE OF PRAIRIE

66. SIGNATURE OF PRAIRIE

67. SIGNATURE OF PRAIRIE

68. SIGNATURE OF PRAIRIE

69. SIGNATURE OF PRAIRIE

70. SIGNATURE OF PRAIRIE

71. SIGNATURE OF PRAIRIE

72. SIGNATURE OF PRAIRIE

73. SIGNATURE OF PRAIRIE

74. SIGNATURE OF PRAIRIE

75. SIGNATURE OF PRAIRIE

76. SIGNATURE OF PRAIRIE

77. SIGNATURE OF PRAIRIE

78. SIGNATURE OF PRAIRIE

79. SIGNATURE OF PRAIRIE

80. SIGNATURE OF PRAIRIE

81. SIGNATURE OF PRAIRIE

82. SIGNATURE OF PRAIRIE

83. SIGNATURE OF PRAIRIE

84. SIGNATURE OF PRAIRIE

85. SIGNATURE OF PRAIRIE

86. SIGNATURE OF PRAIRIE

87. SIGNATURE OF PRAIRIE

88. SIGNATURE OF PRAIRIE

89. SIGNATURE OF PRAIRIE

90. SIGNATURE OF PRAIRIE

91. SIGNATURE OF PRAIRIE

92. SIGNATURE OF PRAIRIE

93. SIGNATURE OF PRAIRIE

94. SIGNATURE OF PRAIRIE

95. SIGNATURE OF PRAIRIE

96. SIGNATURE OF PRAIRIE

97. SIGNATURE OF PRAIRIE

98. SIGNATURE OF PRAIRIE

99. SIGNATURE OF PRAIRIE

100. SIGNATURE OF PRAIRIE

101. SIGNATURE OF PRAIRIE

102. SIGNATURE OF PRAIRIE

103. SIGNATURE OF PRAIRIE

104. SIGNATURE OF PRAIRIE

105. SIGNATURE OF PRAIRIE

106. SIGNATURE OF PRAIRIE

107. SIGNATURE OF PRAIRIE

108. SIGNATURE OF PRAIRIE

109. SIGNATURE OF PRAIRIE

110. SIGNATURE OF PRAIRIE

111. SIGNATURE OF PRAIRIE

112. SIGNATURE OF PRAIRIE

113. SIGNATURE OF PRAIRIE

114. SIGNATURE OF PRAIRIE

115. SIGNATURE OF PRAIRIE

116. SIGNATURE OF PRAIRIE

117. SIGNATURE OF PRAIRIE

118. SIGNATURE OF PRAIRIE

119. SIGNATURE OF PRAIRIE

120. SIGNATURE OF PRAIRIE

121. SIGNATURE OF PRAIRIE

122. SIGNATURE OF PRAIRIE

123. SIGNATURE OF PRAIRIE

124. SIGNATURE OF PRAIRIE

125. SIGNATURE OF PRAIRIE

126. SIGNATURE OF PRAIRIE

127. SIGNATURE OF PRAIRIE

128. SIGNATURE OF PRAIRIE

129. SIGNATURE OF PRAIRIE

130. SIGNATURE OF PRAIRIE

131. SIGNATURE OF PRAIRIE

132. SIGNATURE OF PRAIRIE

133. SIGNATURE OF PRAIRIE

134. SIGNATURE OF PRAIRIE

135. SIGNATURE OF PRAIRIE

136. SIGNATURE OF PRAIRIE

137. SIGNATURE OF PRAIRIE

138. SIGNATURE OF PRAIRIE

139. SIGNATURE OF PRAIRIE

140. SIGNATURE OF PRAIRIE

141. SIGNATURE OF PRAIRIE

142. SIGNATURE OF PRAIRIE

143. SIGNATURE OF PRAIRIE

144. SIGNATURE OF PRAIRIE

145. SIGNATURE OF PRAIRIE

146. SIGNATURE OF PRAIRIE

147. SIGNATURE OF PRAIRIE

148. SIGNATURE OF PRAIRIE

149. SIGNATURE OF PRAIRIE

150. SIGNATURE OF PRAIRIE

151. SIGNATURE OF PRAIRIE

152. SIGNATURE OF PRAIRIE

153. SIGNATURE OF PRAIRIE

154. SIGNATURE OF PRAIRIE

155. SIGNATURE OF PRAIRIE

156. SIGNATURE OF PRAIRIE

157. SIGNATURE OF PRAIRIE

158. SIGNATURE OF PRAIRIE

159. SIGNATURE OF PRAIRIE

160. SIGNATURE OF PRAIRIE

161. SIGNATURE OF PRAIRIE

162. SIGNATURE OF PRAIRIE

163. SIGNATURE OF PRAIRIE

164. SIGNATURE OF PRAIRIE

165. SIGNATURE OF PRAIRIE

166. SIGNATURE OF PRAIRIE

167. SIGNATURE OF PRAIRIE

168. SIGNATURE OF PRAIRIE

169. SIGNATURE OF PRAIRIE

170. SIGNATURE OF PRAIRIE

171. SIGNATURE OF PRAIRIE

172. SIGNATURE OF PRAIRIE

173. SIGNATURE OF PRAIRIE

174. SIGNATURE OF PRAIRIE

175. SIGNATURE OF PRAIRIE

176. SIGNATURE OF PRAIRIE

177. SIGNATURE OF PRAIRIE

178. SIGNATURE OF PRAIRIE

179. SIGNATURE OF PRAIRIE

180. SIGNATURE OF PRAIRIE

181. SIGNATURE OF PRAIRIE

182. SIGNATURE OF PRAIRIE

183. SIGNATURE OF PRAIRIE

184. SIGNATURE OF PRAIRIE

185. SIGNATURE OF PRAIRIE

186. SIGNATURE OF PRAIRIE

187. SIGNATURE OF PRAIRIE

188. SIGNATURE OF PRAIRIE

189. SIGNATURE OF PRAIRIE

190. SIGNATURE OF PRAIRIE

191. SIGNATURE OF PRAIRIE

192. SIGNATURE OF PRAIRIE

193. SIGNATURE OF PRAIRIE

194. SIGNATURE OF PRAIRIE

195. SIGNATURE OF PRAIRIE

196. SIGNATURE OF PRAIRIE

197. SIGNATURE OF PRAIRIE

198. SIGNATURE OF PRAIRIE

199. SIGNATURE OF PRAIRIE

200. SIGNATURE OF PRAIRIE

201. SIGNATURE OF PRAIRIE

202. SIGNATURE OF PRAIRIE

203. SIGNATURE OF PRAIRIE

204. SIGNATURE OF PRAIRIE

205. SIGNATURE OF PRAIRIE

206. SIGNATURE OF PRAIRIE

207. SIGNATURE OF PRAIRIE

208. SIGNATURE OF PRAIRIE

209. SIGNATURE OF PRAIRIE

210. SIGNATURE OF PRAIRIE

211. SIGNATURE OF PRAIRIE

212. SIGNATURE OF PRAIRIE

213. SIGNATURE OF PRAIRIE

214. SIGNATURE OF PRAIRIE

215. SIGNATURE OF PRAIRIE

216. SIGNATURE OF PRAIRIE

217. SIGNATURE OF PRAIRIE

218. SIGNATURE OF PRAIRIE

219. SIGNATURE OF PRAIRIE

220. SIGNATURE OF PRAIRIE

221. SIGNATURE OF PRAIRIE

222. SIGNATURE OF PRAIRIE

223. SIGNATURE OF PRAIRIE

224. SIGNATURE OF PRAIRIE

225. SIGNATURE OF PRAIRIE

226. SIGNATURE OF PRAIRIE

227. SIGNATURE OF PRAIRIE

228. SIGNATURE OF PRAIRIE

229. SIGNATURE OF PRAIRIE

230. SIGNATURE OF PRAIRIE

231. SIGNATURE OF PRAIRIE

232. SIGNATURE OF PRAIRIE

233. SIGNATURE OF PRAIRIE

234. SIGNATURE OF PRAIRIE

235. SIGNATURE OF PRAIRIE

236. SIGNATURE OF PRAIRIE

237. SIGNATURE OF PRAIRIE

238. SIGNATURE OF PRAIRIE

239. SIGNATURE OF PRAIRIE

240. SIGNATURE OF PRAIRIE

241. SIGNATURE OF PRAIRIE

242. SIGNATURE OF PRAIRIE

243. SIGNATURE OF PRAIRIE

244. SIGNATURE OF PRAIRIE

245. SIGNATURE OF PRAIRIE

246. SIGNATURE OF PRAIRIE

247. SIGNATURE OF PRAIRIE

248. SIGNATURE OF PRAIRIE

249. SIGNATURE OF PRAIRIE

250. SIGNATURE OF PRAIRIE

251. SIGNATURE OF PRAIRIE

252.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09763

9778 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Delaware</u>		COUNTY <u>Sussex</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>1 Day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Millville</u>		<u>46 x 3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>Millville</u>			
3. NAME OF DECEASED (Type or Print) <u>Deborah</u> (First) <u>Cooper</u> (Last)				4. DATE OF DEATH (Month) <u>September</u> (Day) <u>23</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 19, 1956</u>	9. AGE last birthday — yrs. <u>3</u> Months <u>4</u> Days		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ernest Cooper</u>				14. MOTHER'S MAIDEN NAME <u>Alice P. Reed</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Ernest Cooper</u>		<u>MILLVILLE Del.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
048X IMMEDIATE CAUSE (A) <u>Shock - Irreversible</u>						INTERVAL BETWEEN ONSET AND DEATH <u>11 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Dysentery</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/22</u> , 19 <u>56</u> , to <u>9/23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/23</u> , 19 <u>56</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William C. Morgan</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury Md</u>		DATE SIGNED <u>9/23/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>9/25/56</u>		NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		LOCATION (City, town, or county) <u>Ocean View - Del.</u>	
24. REC'D BY REGISTRAR DATE <u>9-25-56</u>		REGISTRAR'S SIGNATURE <u>Marjell Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald Jones - Millville</u>		ADDRESS <u>Del.</u>	

2082201XV41

CERTIFICATE OF DEATH

Form No. 1

1. NAME OF DECEASED

MARYLAND

COUNTY OF

CITY OF

STREET

APARTMENT

ZIP CODE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF BURIAL

NAME OF CREMATION

NAME OF URN

NAME OF CASK

NAME OF COFFIN

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

BUREAU V. E.

SEP 28 1956

RECEIVED

SHOOTING

1. NAME OF DECEASED
2. PLACE OF BIRTH
3. DATE OF BIRTH
4. PLACE OF DEATH
5. CAUSE OF DEATH
6. MANNER OF DEATH
7. DATE OF INTERMENT
8. PLACE OF INTERMENT
9. NAME OF FUNERAL HOME
10. NAME OF MINISTER
11. NAME OF CLERGYMAN
12. NAME OF CHURCH
13. NAME OF CEMETERY
14. NAME OF BURIAL
15. NAME OF CREMATION
16. NAME OF URN
17. NAME OF CASK
18. NAME OF COFFIN
19. NAME OF CASKET
20. NAME OF CASKET
21. NAME OF CASKET
22. NAME OF CASKET
23. NAME OF CASKET
24. NAME OF CASKET
25. NAME OF CASKET
26. NAME OF CASKET
27. NAME OF CASKET
28. NAME OF CASKET
29. NAME OF CASKET
30. NAME OF CASKET
31. NAME OF CASKET
32. NAME OF CASKET
33. NAME OF CASKET
34. NAME OF CASKET
35. NAME OF CASKET
36. NAME OF CASKET
37. NAME OF CASKET
38. NAME OF CASKET
39. NAME OF CASKET
40. NAME OF CASKET
41. NAME OF CASKET
42. NAME OF CASKET
43. NAME OF CASKET
44. NAME OF CASKET
45. NAME OF CASKET
46. NAME OF CASKET
47. NAME OF CASKET
48. NAME OF CASKET
49. NAME OF CASKET
50. NAME OF CASKET
51. NAME OF CASKET
52. NAME OF CASKET
53. NAME OF CASKET
54. NAME OF CASKET
55. NAME OF CASKET
56. NAME OF CASKET
57. NAME OF CASKET
58. NAME OF CASKET
59. NAME OF CASKET
60. NAME OF CASKET
61. NAME OF CASKET
62. NAME OF CASKET
63. NAME OF CASKET
64. NAME OF CASKET
65. NAME OF CASKET
66. NAME OF CASKET
67. NAME OF CASKET
68. NAME OF CASKET
69. NAME OF CASKET
70. NAME OF CASKET
71. NAME OF CASKET
72. NAME OF CASKET
73. NAME OF CASKET
74. NAME OF CASKET
75. NAME OF CASKET
76. NAME OF CASKET
77. NAME OF CASKET
78. NAME OF CASKET
79. NAME OF CASKET
80. NAME OF CASKET
81. NAME OF CASKET
82. NAME OF CASKET
83. NAME OF CASKET
84. NAME OF CASKET
85. NAME OF CASKET
86. NAME OF CASKET
87. NAME OF CASKET
88. NAME OF CASKET
89. NAME OF CASKET
90. NAME OF CASKET
91. NAME OF CASKET
92. NAME OF CASKET
93. NAME OF CASKET
94. NAME OF CASKET
95. NAME OF CASKET
96. NAME OF CASKET
97. NAME OF CASKET
98. NAME OF CASKET
99. NAME OF CASKET
100. NAME OF CASKET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09764

9779

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomac</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Church</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>83X-3</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Vida</u> <u>Cunningham</u>				4. DATE OF DEATH Month Day Year <u>September</u> <u>17</u> <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 4, 1913</u>	9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>				13. FATHER'S NAME <u>JAMES FREEMAN</u>			
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Samuel Cunningham - New Church, Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra-ventricular Cerebral Hemorrhage</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vascular Disease</u> DUE TO (c) <u>Chronic Nephritis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Sept. 15, 1956</u> to <u>Sept. 17, 1956</u> that I last saw the deceased alive on <u>Sept. 17, 1956</u> and that death occurred at <u>7:25 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Herbert Sembley</u> M.D.				ADDRESS (Street, city or town, state) <u>4006 Church St. Salisbury, Md.</u>			
DATE SIGNED <u>9/17/56</u>				PHYSICIAN'S NAME (Type) <u>G. Herbert Sembley, Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-20-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>R. B. Wharton Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Parkley, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u>				ADDRESS <u>New Church, Va.</u>		24a. REC'D BY REGISTRAR DATE <u>9-18-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Marj W. Holloway</u>							

BUREAU V. S.

SEP 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9780

CERTIFICATE OF DEATH

Reg. Dist. No. 0976532

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 608 E. Isabella St		d. STREET ADDRESS 608 E. Isabella St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle JANE Last DAVIS		4. DATE OF DEATH Month SEPT. Day 16 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1871
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work (Retired)		10b. KIND OF BUSINESS OR INDUSTRY at own home	
11. BIRTHPLACE (State or foreign country) Wicomico Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Samuel Kelly		14. MOTHER'S MAIDEN NAME Elizabeth Dove	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Harry Wachsmuth (Daughter) Address 608 E. Isabella St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 434.1 Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1946 , 19____, to _____, 19____, that I last saw the deceased alive on 9-15-56 , 19____, and that death occurred at 1:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Lee L Lawry		ADDRESS (Street, city or town, state) Fruitland, Maryland DATE SIGNED Sept. 17 1956	
PHYSICIAN'S NAME (Type) Dr. Lee Lawry			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 18, 1956	22c. NAME OF CEMETERY OR CREMATORY Smullen Cemetery (Worcester Co.)	22d. LOCATION (City, town, or county) (State) St. Luke-Fruitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME—SALISBURY, MD.		24a. REC'D BY REGISTRAR SEP 18 1956 24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]	
NAME OF FATHER [Illegible]		NAME OF MOTHER [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF REGISTRAR [Illegible]	
CITY OF BALTIMORE [Illegible]		COUNTY OF BALTIMORE [Illegible]	

BUREAU V. 2

SEP 18 1956

RECEIVED

09766

9781

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <div>Wicomico</div>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <div>Maryland</div>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div>Salisbury</div>		b. COUNTY <div>Wicomico</div>	
c. LENGTH OF STAY IN lb <div>5 Days</div>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div>Bivalve</div>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <div>Peninsula Gen. Hospital</div>		d. STREET ADDRESS <div></div>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <div>Harry</div>		4. DATE OF DEATH Month <div>Sept.</div>	
5. SEX <div>M</div>		Day <div>4,</div>	
6. COLOR OR RACE <div>White</div>		Year <div>19 56</div>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <div>9/19/1886</div>	
9. AGE (In years last birthday) <div>69 yrs.</div>		IF UNDER 1 YEAR Months <div>11</div>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div>Clerical Work</div>		IF UNDER 24 HRS. Days <div>15</div>	
10b. KIND OF BUSINESS OR INDUSTRY <div>Telephone Co.</div>		Hours <div></div>	
11. BIRTHPLACE (State or foreign country) <div>Buffalo, N.Y.</div>		Min. <div></div>	
12. CITIZEN OF WHAT COUNTRY? <div>U.S.</div>			
13. FATHER'S NAME <div>John George Dieter</div>		14. MOTHER'S MAIDEN NAME <div>Caroline Hinderern</div>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <div>No</div>		16. SOCIAL SECURITY NO. <div>090-03-334</div>	
17. INFORMANT Address <div>Mrs. Anna Dieter, Bivalve, Maryland</div>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <div>Coronary Insufficiency & Acute Cardiac Collapse</div> DUE TO <div>Many severe attacks of Bronchial Asthma</div> DUE TO <div>Bothered</div> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <div></div>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <div></div>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <div>19</div>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <div></div>		20f. (City or town) <div></div>	
(County) <div></div>		(State) <div></div>	
21. I certify that I attended the deceased from <div>Aug 31, 1956</div> to <div>Sept 4, 1956</div> that I last saw the deceased alive on <div>Sept 4, 1956</div> , and that death occurred at <div>M</div> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <div></div>	
DATE SIGNED <div></div>			
ACTUAL SIGNATURE <div>Mr. Carrie I. Hearn</div>		M.D. <div></div>	
PHYSICIAN'S NAME (Type) <div>DR. CARRIE I. HEARN 226 N. Wisconsin St. Salisbury</div>			
22a. NAME OF CEMETERY OR CREMATORY <div>Spring Hill Memory Garden</div>		22b. LOCATION (City, town, or county) (State) <div>Hebron, Maryland</div>	
22c. NAME OF CEMETERY OR CREMATORY <div>Spring Hill Memory Garden</div>		22d. LOCATION (City, town, or county) (State) <div>Hebron, Maryland</div>	
23. FEDERAL DIRECTOR'S SIGNATURE <div>C. H. Morris</div>		ADDRESS <div>Bivalve, Maryland</div>	
24a. REC'D BY REGISTRAR DATE <div>SEP 14 1956</div>		24b. REGISTRAR'S SIGNATURE <div>Mary H. Holloway</div>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9782

CERTIFICATE OF DEATH

09767 337

Reg. Dist. No. 40

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springhill Sanatorium</u>		d. STREET ADDRESS <u>12 Salisbury</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Louise</u> Last <u>Everingham</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28, 1867</u>
9. AGE (In years, last birthday) <u>89</u>		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>16</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Wooters</u>		14. MOTHER'S MAIDEN NAME <u>Martha Coulbourne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Robert Everingham</u>		Address <u>Denton, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular renal disease</u> DUE TO (b) <u>442X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>442X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>442X</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>55</u> , to <u>Sept. 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept. 16</u> , 19 <u>56</u> , and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip A Insley</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md</u>	
PHYSICIAN'S NAME (Type) <u>Philip A Insley</u>		DATE SIGNED <u>9/18/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>Sept. 20, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>	22d. LOCATION (City, town, or county) (State) <u>Denton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Vergel</u>		ADDRESS <u>herndon How Denton</u>	
24a. REC'D BY REGISTRAR <u>9/20/56</u>		24b. REGISTRAR'S SIGNATURE <u>Harry Holloman</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED: *William H. Wood*
AGE: *70*
SEX: *M*
DATE OF DEATH: *Sept 10, 1956*
PLACE OF DEATH: *Home*
CAUSE OF DEATH: *Heart Disease*
DISEASE OR INJURY: *Heart Disease*
MANNER OF DEATH: *Natural*
SIGNATURE OF PHYSICIAN: *[Signature]*
SIGNATURE OF WITNESSES: *[Signature]*
SIGNATURE OF DECEASED: *[Signature]*

BUREAU V. 1

SEP 24 1956

RECEIVED

[Handwritten notes and signatures at the bottom of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9783

CERTIFICATE OF DEATH

09768

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				d. STREET ADDRESS 108 West Isabella St			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CHARLES Middle THOMPSON Last FISHER				4. DATE OF DEATH Month SEPTEMBER Day 19th Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 7, 1879		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor-Physician		10b. KIND OF BUSINESS OR INDUSTRY Physician		11. BIRTHPLACE (State or foreign country) Princess Anne, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles Thompson Fisher				14. MOTHER'S MAIDEN NAME Hannah Palmatary			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Ellen McMaster Fisher (Wife) Address 108 W. Isabella St Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause prevailing for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency 411X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aortic Stenosis, Rheumatic Heart Disease DUE TO (c) Disease						INTERVAL BETWEEN ONSET AND DEATH one year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 19 56 to Sept. 19 56 , that I last saw the deceased alive on Sept. 19 56 , and that death occurred at 9:45A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE David J. Gilmore M.D.				ADDRESS (Street, city or town, state) Medical Center DATE SIGNED Sept. 1956			
PHYSICIAN'S NAME (Type) Dr. David J. Gilmore M.D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 21, 1956		22c. NAME OF CEMETERY OR CREMATORY Manokin Cemetery		22d. LOCATION (City, town, or county) (State) Princess Anne, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR SEP 21 1956		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		65		M		W		JAN 21 1956		BALTIMORE, MD	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		FILE NO.	
100 N. LINDEN ST.		LABORER		HEART DISEASE		NATURAL		100		100	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		SINGLE		MARRIED	
JAN 21 1891		BALTIMORE, MD		HIGH SCHOOL		MARRIED		MARRIED		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		FILE NO.	
JAN 21 1956		BALTIMORE, MD		HEART DISEASE		NATURAL		100		100	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		SINGLE		MARRIED	
JAN 21 1891		BALTIMORE, MD		HIGH SCHOOL		MARRIED		MARRIED		MARRIED	

BUREAU A. 3

SEP 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9784

CERTIFICATE OF DEATH

09769

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First John Middle Floyd Last Floyd				4. DATE OF DEATH Month September Day 10 Year 1956			
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 27/1923		9. AGE (In years for birthday) 33 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fabric		10b. KIND OF BUSINESS OR INDUSTRY Cement		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred Floyd				14. MOTHER'S MAIDEN NAME Bell M. M. M.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Jessie S. S. S. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 322.1 DUE TO Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Passive Congestion of liver DUE TO 5 days (c) Chronic Alcoholic Intoxication DUE TO 2 weeks						INTERVAL BETWEEN ONSET AND DEATH 3 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemorrhagic Gastritis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Salisbury Wicomico Md		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 10, 1956 to Sept. 10, 1956 that I last saw the deceased alive on Sept. 10, 1956 , and that death occurred at 10:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE G. Herbert Sempley M.D.				ADDRESS (Street, city or town, state) Salisbury Md DATE SIGNED 9/11/56			
PHYSICIAN'S NAME (Type) G. Herbert Sempley							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-16-56		22c. NAME OF CEMETERY OR CREMATORY Lawrenceville		22d. LOCATION (City, town, or county) (State) Lawrenceville, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Hartman ADDRESS N. W. Church, Va.				24a. REC'D BY REGISTRAR DATE 9-11-56		24b. REGISTRAR'S SIGNATURE Mary W. Holloway	

SEP 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09770

9785

CERTIFICATE OF DEATH

Reg. Dist. No.

330

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	c. LENGTH OF STAY IN 1b 2 yr. 10 mo.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS --	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Annie Middle - Last Forrester		4. DATE OF DEATH Month September Day 21, Year 19 56	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1860
9. AGE (In years last birthday) 96 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Downs	
14. MOTHER'S MAIDEN NAME Harkless		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.	
16. SOCIAL SECURITY NO. --		17. INFORMANT Deer's Head State Hospital Records, Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of the left hip with surgical repair.		INTERVAL BETWEEN ONSET AND DEATH 904.7	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Nov. 20, 1953 , to Sept. 21, 1956 , that I last saw the deceased alive on Sept. 21, 1956 , and that death occurred at 7: P.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE L. V. Maldve		ADDRESS (Street, city or town, state) Deer's Head State Hospital	
PHYSICIAN'S NAME (Type) L. V. Maldve, M.D.		DATE SIGNED 9/22/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-25-56	
22c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery		22d. LOCATION (City, town, or county) (State) Centreville, Queen Anne Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.		24a. REC'D BY REGISTRAR SEP 26 1956	
24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

J. E. Stewart, General Home, Baltimore, Md.

SEP 26 1956

BUREAU V. E.

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9786

CERTIFICATE OF DEATH

Reg. Dist. No.

09771 ✓

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 6 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) First HESTER Middle Last FREEMAN		4. DATE OF DEATH Month Sept. Day 16 Year 19 56	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/5/1878
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Bonds		14. MOTHER'S MAIDEN NAME -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. -	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Recurrent cerebral hemorrhage 443X DUE TO Hypertensive arteriosclerotic cardiovascular disease with aortic sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) - (c) -		INTERVAL BETWEEN ONSET AND DEATH 4 days ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 8 , 19 56 , to Sept. 16 , 19 56 , that I last saw the deceased alive on Sept. 16 , 19 56 , and that death occurred at 11:22P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE V. Juerman M.D.		ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 9/17/56	
PHYSICIAN'S NAME (Type) V. Juerman, M. D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		Sept 22 1956	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Mt Auburn		Baltimore MD	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Ringgold		24a. REC'D BY REGISTRAR SEP 19 1956	
ADDRESS 14637 Carey		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		SEP 20 1956	
AGE		SEX	
65		M	
RACE		OCCUPATION	
W		RETIRED	
BIRTHPLACE		PLACE OF BIRTH	
MD		MD	
EDUCATION		MARRIAGE	
HS		M	
RELIGION		CAUSE OF DEATH	
C		HEART DISEASE	
HABIT		MANNER OF DEATH	
N		N	
PLACE OF DEATH		DATE OF DEATH	
HOSPITAL		SEP 20 1956	
NAME OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
J. H. HARRIS		J. H. HARRIS	
NAME OF FUNERAL HOME		SIGNATURE OF FUNERAL HOME	
J. H. HARRIS		J. H. HARRIS	
NAME OF BURIAL PLACE		SIGNATURE OF BURIAL PLACE	
J. H. HARRIS		J. H. HARRIS	

BUREAU V. B.

SEP 20 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9787

CERTIFICATE OF DEATH

09772

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>VIRGINIA</i>		COUNTY <i>ACCOMACK</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Salisbury</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>MAKEMIE PARK</i>		83X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Peninsula General Hosp</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>Gertrude</i> (First) <i>Groton</i> (Middle) (Last)				4. DATE OF DEATH (Month) <i>9</i> (Day) <i>13</i> (Year) <i>1956</i>			
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Mar. 21 1866</i>	9. AGE last birthday <i>90</i> yrs.	IF UNDER 1 YEAR Months <i>6</i> Days <i>2</i>		IF UNDER 24 HRS. Hours <i>2</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>VIRGINIA</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Wm. BRITTINGHAM</i>				14. MOTHER'S MAIDEN NAME <i>Charlotte Bunting</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Lewis Leonard New Church, Va.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
491X IMMEDIATE CAUSE (A) <i>Cerebral Thrombosis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Bronchial Pneumonia</i>						<i>3 days</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Sept 22, 1956</i> to <i>Sept 23, 1956</i> , that I last saw the deceased alive on <i>Sept 23, 1956</i> , and that death occurred at <i>5:35 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Thomas C. Hill Jr. M.D.</i>				ADDRESS (Street, city, town, state) <i>224 N. Division St. Salisbury</i> DATE SIGNED <i>9/23/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		DATE THEREOF <i>25</i>		NAME OF CEMETERY OR CREMATORY <i>DOWNINGS</i>		LOCATION (City, town, or county) (State) <i>OAK HALL VA</i>	
24. REC'D BY REGISTRAR <i>9-25-56</i>		REGISTRAR'S SIGNATURE <i>Mary W. Halliday</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Mrs. W. A. Shields</i>		ADDRESS <i>New Church</i>	

CERTIFICATE OF DEATH

1955

AT BIRTH FOR PERSON BORN IN BALTIMORE

MARITAL STATUS

Married

Married

Final Cause of Death

Heart

Failure

23 23 23

BUREAU V. B.

SEP 28 1956

RECEIVED

1 9788 Items 11,12 Film G202 9-10-56 et CERTIFICATE OF DEATH

Reg. Dist. No.

09773

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>203 Washington St.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>E</u> Last <u>ESTHER-HANCOCK</u>		4. DATE OF DEATH Month <u>September</u> Day <u>1</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 30, 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Pocomoke City, Md.</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John T. Webb</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE V. FARNISS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Norman Fox (Sister)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>unknown</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-20, 1956</u> to <u>9-1, 1956</u> that I last saw the deceased alive on <u>9-1, 1956</u> , and that death occurred at <u>6:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilbur R. Ellis Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>9-1-56</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Wilbur R. Ellis Jr. Md</u>		Medical Center - Salisbury, Maryland 9/1/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 3rd, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baptist Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>FOX & JAMES FUNERAL HOME - EASTVILLE, VIRGINIA</u>		24a. REC'D BY REGISTRAR <u>SEP 4 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

SEP 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9789
CERTIFICATE OF DEATH

Reg. Dist. No. 832

09774

1. PLACE OF DEATH o. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Wicomico</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>Quantico</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hosp. TA</i>		d. STREET ADDRESS <i>Route #1, P.O. Box 128</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Harmon</i>		4. DATE OF DEATH Month Day Year <i>September 17 1956</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>September 17, 1936</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. AGE (In years last birthday) <i>25</i>	9c. IF UNDER 1 YEAR Months Days Hours Min. <i>25</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	11. BIRTHPLACE (State or foreign country) <i>U.S.A</i>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <i>Sarah Harmon</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Sarah Harmon</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity (Wt 1-4; approximate gestation 2 1/2 - 2 3 weeks)</i> DUE TO (b) <i>Placenta previa</i> DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 hours</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>17 Sept, 1956</i> to <i>17 Sept, 1956</i> , that I last saw the deceased alive on <i>17 Sept, 1956</i> , and that death occurred at <i>1:45 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. W. Sanderson Jr.</i>		ADDRESS (Street, city or town, state) <i>Salisbury, Maryland</i>	
PHYSICIAN'S NAME (Type) <i>R. W. Sanderson, Jr.</i>		DATE SIGNED <i>11/9/56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>9-19-56</i>	22b. DATE THEREOF <i>9-19-56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Lukes Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Quantico Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Cornelius Musick</i> ADDRESS <i>Burwalve md.</i>		24a. REC'D BY REGISTRAR <i>DATE 9-19-56</i>	24b. REGISTRAR'S SIGNATURE <i>Mary W. Holloway</i>

208236960

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9790 CERTIFICATE OF DEATH

Reg. Dist. No.

09775
337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 1 (St Luke)		d. STREET ADDRESS R.D.# 1 (St Luke)	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SAMUEL Middle CLARENCE Last HITCH		4. DATE OF DEATH Month SEPTEMBER Day 13th Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 10, 1880
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 1 Days 3	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Somerset Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Samuel H. Hitch		14. MOTHER'S MAIDEN NAME Hettie Ann Driscoll	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mr. Carroll Hitch (Son) R.D.# 1 Salisbury, Maryland		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary occlusion DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 hours 8 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Time of death to , 19 , that I last saw the deceased alive on 19 , and that death occurred at 4:45A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Camden Ave. DATE SIGNED Sept. 14 1956			
ACTUAL SIGNATURE Earl L. Royer		M.D. 	
PHYSICIAN'S NAME (Type) Dr. Earl L. Royer MD		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 16, 1956	
22c. NAME OF CEMETERY OR CREMATORY NASSAWANGO CHURCH CEMETERY		22d. LOCATION (City, town, or county) (State) Salisbury, Snow Hill Rd R.D.#	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR SEP 17 1956	
24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

SEP 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09776

Item 3: G110
I-29-37L

9791

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>in Mrs. Kieffer's Office</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>		c. LENGTH OF STAY IN 1b <u>3 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HERMAN</u> Middle <u>JEROME</u> Last <u>Hudson</u> <u>Jerome</u>		4. DATE OF DEATH Month <u>September</u> Day <u>28</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 6, 1887</u>
9a. AGE (In years last birthday) <u>69</u> yrs.		9b. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FDP M</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Thomas Hudson</u>		14. MOTHER'S MAIDEN NAME <u>Cully Handy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Hospital Records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatous</u> <u>162X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Brachyogenic carcinoma</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic pyelonephritis; Siphylis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		(County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u>June 6</u> , 1956, to <u>Sept 28</u> , 1956, that I last saw the deceased alive on <u>September 28</u> , 1956, and that death occurred at <u>5:10 M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>9/28/56</u>			
ACTUAL SIGNATURE <u>Andrus Grisolia</u> M.D. <u> </u>			
PHYSICIAN'S NAME (Type) <u>Dr. A. Grisolia</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-2-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cold Spring</u>	22d. LOCATION (City, town, or county) (State) <u>Handle Tree Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgo. Whento - New Church, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>10-6-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>			

1956 6 OCT

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

197777

228

9792

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 4 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Samuel Middle Henry Last Hudson				4. DATE OF DEATH Month September Day 11 Year 1956			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/22/1887		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Newark, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Sally Hudson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, chronic 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Chronic pyelonephritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Ca. of prostate gland							INTERVAL BETWEEN ONSET AND DEATH 11 months ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 3 , 19 56 , to Sept. 11 , 19 56 , that I last saw the deceased alive on Sept. 11 , 19 56 , and that death occurred at 12 noon , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. V. Juerman		M.D.		ADDRESS (Street, city or town, state) Deer's Head State Hospital		DATE SIGNED 9/11/56	
PHYSICIAN'S NAME (Type) V. Juerman, M. D.		Salisbury, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-16-56		22c. NAME OF CEMETERY OR CREMATORY Cedar Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Newark, Worcester Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 17 1956	
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9793

CERTIFICATE OF DEATH

Reg. Dist. No. 09778 337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Flower St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Infant</u> Middle <u>Tarman</u> Last <u>Tarman</u>		4. DATE OF DEATH Month <u>September</u> Day <u>12</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 10 1956</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>2</u> yrs. IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. IF UNDER 24 HRS.
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Marjorie Tarman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 760.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Intrauterine hemorrhage</u> DUE TO (c) <u>Prematurity</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9/10</u> , 19 <u>56</u> , to <u>9/12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/12/56</u> , 19 <u>56</u> , and that death occurred at <u>4:45 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Morgan</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Md.</u> DATE SIGNED <u>9/12/56</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-13-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Berlin, Worcester Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart</u>		24. REC'D BY REGISTRAR <u>SEP 17 1956</u>	
ADDRESS <u>Funeral Home Salisbury, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Thos. J. Holloway</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS, TENN.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT	
APRIL 4, 1968		MEMPHIS, TENN.		SHOOTING		HOMICIDE		FIREARM		DR. J. H. HARRIS	
TIME OF DEATH		HOURS		MINUTES		SECONDS		TEMPERATURE		PULSE	
10:00 AM		10		00		00		98.6		60	
WEIGHT		HEIGHT		BUILD		COMPLEXION		HAIR		EYES	
170		5'10"		M		F		BRN		BLU	
EDUCATION		OCCUPATION		MARRIAGE		RELIGION		SOCIETY		HISTORY	
HIGH SCHOOL		ATTORNEY		MARRIED		METHODIST		MEMBER		NONE	
FAMILY HISTORY		PREVIOUS DEATHS		PREVIOUS INJURIES		PREVIOUS DISEASES		PREVIOUS SURGERIES		PREVIOUS HOSPITALS	
NONE		NONE		NONE		NONE		NONE		NONE	
FAMILY HISTORY		PREVIOUS DEATHS		PREVIOUS INJURIES		PREVIOUS DISEASES		PREVIOUS SURGERIES		PREVIOUS HOSPITALS	
NONE		NONE		NONE		NONE		NONE		NONE	
FAMILY HISTORY		PREVIOUS DEATHS		PREVIOUS INJURIES		PREVIOUS DISEASES		PREVIOUS SURGERIES		PREVIOUS HOSPITALS	
NONE		NONE		NONE		NONE		NONE		NONE	

BUREAU V. 3

SEP 17 1956

RECEIVED

9814 CERTIFICATE OF DEATH

Reg. Dist. No. 335

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Sharptown</u>		<u>76 yrs</u>		TOWN <u>Sharptown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>John</u> (Middle) <u>Thomas</u> (Last) <u>Jones</u>				(Month) <u>Sept.</u> (Day) <u>24</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR		
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>7-18-1880</u>	<u>76</u> yrs.	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer</u>		<u>Basket Factory</u>		<u>Wicomico County, Md.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Henry Jones</u>				<u>Elizabeth Kennerly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>216-07-5013</u>		<u>Mary Jones, Sharptown, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
610X IMMEDIATE CAUSE (A) <u>Acute Distention Heart</u>						<u>3 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Prostatic Hypertrophy</u>						<u>3 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Prostatic Hypertrophy</u>						<u>10 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
<u>9/13/56</u>		<u>Prostatic Hypertrophy</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>Sept 8</u> , 19 <u>56</u> , to <u>Sept 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 24</u> , 19 <u>56</u> , and that death occurred at <u>6:45 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>H. S. Kuhlman</u>				ADDRESS (Street, city, town, state) <u>Sharptown Md</u>		DATE SIGNED <u>9/25/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9-26-56</u>		<u>Riverton</u>		<u>Riverton, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>SEP 28 1956</u>		<u>Mary C. Owens</u>		<u>Charles W. Grand</u>		<u>Sharptown Md</u>	

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

332 ✓

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

Late due to circ. being sent to Welfare Dept.
10/19/56
MB.

BUREAU V. M.

OCT 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9795

CERTIFICATE OF DEATH

09780

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>				c. LENGTH OF STAY IN 1b <u>17X</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>H.</u> Last <u>Lankford</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>19</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1896</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oyster shucker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oyster shucking</u>		11. BIRTHPLACE (State or foreign country) <u>Seaford, Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Lankford</u>				14. MOTHER'S MAIDEN NAME <u>Mary ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>226-09-1510</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca. of lung with metastases</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr. ?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 17</u> , 19 <u>56</u> , to <u>Sept. 19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept. 19</u> , 19 <u>56</u> , and that death occurred at <u>3:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>V. Juerman</u>				ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>9/19/56</u>			
PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-23-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Old Fellows Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barker McCreesh</u>				24a. REC'D BY REGISTRAR DATE <u>9-24-56</u>		24b. REGISTRAR'S SIGNATURE <u>Warry W. Holloway</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF DEATH [Illegible]		5. TIME OF DEATH [Illegible]		6. PLACE OF DEATH [Illegible]	
7. CAUSE OF DEATH [Illegible]		8. MANNER OF DEATH [Illegible]		9. PLACE OF BIRTH [Illegible]	
10. OCCUPATION [Illegible]		11. EDUCATION [Illegible]		12. RELIGION [Illegible]	
13. MARITAL STATUS [Illegible]		14. PREVIOUS MARRIAGES [Illegible]		15. PREVIOUS DEATHS [Illegible]	
16. SIGNATURE OF DECEASED [Illegible]		17. SIGNATURE OF WITNESS [Illegible]		18. SIGNATURE OF PHYSICIAN [Illegible]	
19. SIGNATURE OF CORONER [Illegible]		20. SIGNATURE OF JURY [Illegible]		21. SIGNATURE OF JUDGE [Illegible]	
22. SIGNATURE OF CLERK [Illegible]		23. SIGNATURE OF REGISTRAR [Illegible]		24. SIGNATURE OF ARCHIVIST [Illegible]	

BUREAU V. 1

SEP 26 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09781

9796

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 632 Liberty St		d. STREET ADDRESS 632 Liberty St		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First PHILLIP Middle RODNEY Last LEWIS		4. DATE OF DEATH Month Sept. Day 4th Year 19 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1897	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 4 Days 16	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Barber of own Shop		
11. BIRTHPLACE (State or foreign country) Georgetown, Delaware		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Joshua Lewis		14. MOTHER'S MAIDEN NAME Unk		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. # 1		16. SOCIAL SECURITY NO. 218 -05-9079		
17. INFORMANT Mrs. Georgia M. Lewis (Wife) Address 632 Liberty St. Salisbury, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C.V. Disease DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 4-20 , 19 56 , to 9-14 , 19 56 , that I last saw the deceased alive on 9-10 , 19 56 , and that death occurred at 7:15 A. M, from the causes and on the date stated above.				
ACTUAL SIGNATURE W. B. Smith M.D.		ADDRESS (Street, city or town, state) Medical Center (Office) Sept. 5 1956		
DATE SIGNED				
PHYSICIAN'S NAME (Type) Dr. William B. Smith M.D.		Salisbury, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 6, 1956	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	
22d. LOCATION (City, town, or county) Salisbury, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR SEP 10 1956		
24b. REGISTRAR'S SIGNATURE Mary H. Holloway				

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		Male		45		1911		Maryland		Baltimore		Maryland		U.S.A.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
1956		Home		Heart Disease		Natural		Coronary Artery Disease		Chest Pain		Medicine		None	
DATE OF REPORT		PLACE OF REPORT		REPORTED BY		RELATIONSHIP		SIGNATURE		TITLE		HOSPITAL		PHYSICIAN	
1956		Home		John H. Harris		Son		[Signature]		Son		None		None	
DATE OF INTERVIEW		PLACE OF INTERVIEW		INTERVIEWED BY		RELATIONSHIP		SIGNATURE		TITLE		HOSPITAL		PHYSICIAN	
1956		Home		[Signature]		Son		[Signature]		Son		None		None	

BUREAU V. S.

SEP 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9797

CERTIFICATE OF DEATH

09782

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS 314 Naylor St.	
3. NAME OF DECEASED (Type or print) First JULIA Middle POWELL Last LIVINGSTON		4. DATE OF DEATH Month Sept. Day 7 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 3, 1883
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 7 Days 4	IF UNDER 24 HRS. Hours 4 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY at own Home	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME George Washington Cluff	
14. MOTHER'S MAIDEN NAME Mary Ann Taylor		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mr. W. Irving Livingston (Husband) 314 Naylor St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) degenerative heart disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/4 , 19 56 , to 9/7 , 19 56 that I last saw the deceased alive on 9/6 , 19 56 , and that death occurred at 9:00 A. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Andrew C. Mitchell		ADDRESS (Street, city or town, state) Maryland Ave. (Office) DATE SIGNED Sept 7 1956	
PHYSICIAN'S NAME (Type) Dr. Andrew C. Mitchell		M.D. Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF SEPT. 9, 1956	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR SEP 10 1956 24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09783

9798 CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>SOMERSET</u>			
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>		<u>6 Hours</u>		TOWN <u>Pocomoke</u>		<u>19X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>R.F.D. 1</u>			
3. NAME OF DECEASED (Type or Print) <u>MARGIE E. LONG</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>SEPTEMBER 24 19 56</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MARCH 5, 1889</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN L. MERRILL</u>				14. MOTHER'S MAIDEN NAME <u>MARY ANNIE HICKMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>None</u>		16. SOCIAL SECURITY NO. <u>2-18-30-1677</u>		17. INFORMANT & ADDRESS <u>HUGH LONG (Pocomoke)</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
151X IMMEDIATE CAUSE (A) <u>CORONARY ARTERY THROMBOSIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>PARALYTIC ILEUS</u>				<u>7 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>CARCINOMA OF STOMACH (Antral) (11/15/54)</u>				<u>6 mos?</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CARCINOMATOSIS (LUNG, PERITONEAL)</u>				<u>" " ?</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/7</u> , 19 <u>56</u> , to <u>9/24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/24</u> , 19 <u>56</u> , and that death occurred at <u>5:00</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Dr. J. L. Gardiner, Jr.</u>		M.D. <u>3215 D.U. ST. SALISBURY MD</u>		DATE SIGNED <u>9/24/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>SEPT. 26, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>PRESBYTERIAN</u>		LOCATION (City, town, or county) (State) <u>Pocomoke MD</u>	
24. REC'D BY REGISTRAR <u>SEP 27 1956</u>		REGISTRAR'S SIGNATURE <u>Mary H. Zallway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>		ADDRESS <u>Pocomoke Md.</u>	

BUREAU OF HEALTH - BALTIMORE 12

CERTIFICATE OF DEATH

Reg. Code No.

1. DEATH NUMBER (FROM CHARGE)

PLACE OF DEATH

DEATH NO.
DATE OF DEATH
TIME OF DEATH

1. DEATH NUMBER (FROM CHARGE)
2. DEATH NUMBER (FROM CHARGE)
3. DEATH NUMBER (FROM CHARGE)

DEATH

DEATH

1. DEATH NUMBER (FROM CHARGE)

1. DEATH NUMBER (FROM CHARGE)

1. DEATH NUMBER (FROM CHARGE)

1. DEATH NUMBER (FROM CHARGE)

BUREAU V. S.

SEP 27 1956

RECEIVED

RECEIVED

9799

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2 yrs. 3 da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro		05X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS ---		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Etta		First May		Middle McKinley		Last September 10, 1956	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 6, 1863	
9. AGE (In years last birthday) 93		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Oliver Boyer				14. MOTHER'S MAIDEN NAME Glottfelty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. --		17. INFORMANT Deer's Head State Hospital, Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic pyelonephritis DUE TO (c) Chronic pyelonephritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic pyelonephritis INTERVAL BETWEEN ONSET AND DEATH 2 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. 11 p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 7, 1954 , to Sept. 10, 1956 , that I last saw the deceased alive on Sept. 10, 1956 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 9/11/56 ACTUAL SIGNATURE L. V. Maldve, M. D. M.D. Salisbury, Maryland PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 13, 1956		22c. NAME OF CEMETERY OR CREMATORY Salisbury		22d. LOCATION (City, town, or county) (State) Salisbury, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Morrison				24a. REC'D BY REGISTRAR DATE 9-15-56		24b. REGISTRAR'S SIGNATURE Marshall Hollman	

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9800

CERTIFICATE OF DEATH

Reg. Dist. No.

09785

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>Accomac</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>107 SAUSAGE STREET</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>E</u> Last <u>MEARS</u>		4. DATE OF DEATH Month <u>September</u> Day <u>11</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 17, 1927</u>
9. AGE (In years last birthday) <u>29</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical Mathematician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Social Security</u>	
11. BIRTHPLACE (State or foreign country) <u>Chincoteague, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CARDINAL L MEARS</u>		14. MOTHER'S MAIDEN NAME <u>Mollie CLARK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>1945-1947</u>		16. SOCIAL SECURITY NO. <u>151X</u>	
17. INFORMANT <u>Mrs Norma Mears</u> Address <u>Chincoteague, Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>151X</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/17/56</u> , 19 <u>56</u> , to <u>9/11/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9-11-56</u> , 19 <u>56</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. Bellis</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>9-11-56</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/13/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MECHANICS</u>		22d. LOCATION (City, town, or county) (State) <u>Chincoteague VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm B. Salyer</u> ADDRESS		24a. REC'D BY REGISTRAR <u>9-15-56</u> 24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

BUREAU V.

SEP 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **09786**

Film #204

9801

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) P.G. Hospt.		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 805 Brown Street. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Benjamin Middle Burton Last Mitchell		4. DATE OF DEATH Month Sept. Day 17. Year 19 56.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20. 1886.
9. AGE (In years birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY At. Salisbury Fire Dept #2)	
11. BIRTHPLACE (State or foreign country) Whaleyville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Milbourne Mitchell		14. MOTHER'S MAIDEN NAME Sarah Hitchens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Ida Mitchell (Wife) Address 805 Brown St. Salisbury Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Staphylococcus food poisoning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Staphylococcus food poisoning DUE TO Staphylococcus food poisoning DUE TO Staphylococcus food poisoning			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ingested infected pork.	
20c. TIME OF INJURY Month, Day, Year Hour P o. m. 2-16 p. m. 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) At home.	
20f. (City or town) Salisbury (County) Wicomico (State) Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 20. 56.	
22c. NAME OF CEMETERY OR CREMATORY Farsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Company		24a. REC'D BY REGISTRAR SEP 28 1956	
24b. REGISTRAR'S SIGNATURE Mary W. Holloway		DATE SIGNED 19-25-56	

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

EXAMINER'S NAME (Type) **Earl L. Royer, M.D.**

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records, or to burial, cremation, or removal.

TWO FOR ONE CERTIFICATE FILM G204 - 9/28/56 - mb

BUREAU V. 2

OCT 1 1956

RECEIVED

1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. For a burial, cremation, or removal, see the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09787

9802

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ o. STATE <u>New York</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN lb <u>minutes</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>995 Union Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Karen</u> Middle <u>Mosely</u> Last		4. DATE OF DEATH Month <u>9</u> Day <u>29</u> Year <u>56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 2, 1956</u>
9. AGE (In years last birthday) <u>6</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>27</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Bronx, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Earl Mosely</u>		14. MOTHER'S MAIDEN NAME <u>Erma Davenport</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Father: Earl Mosely, 995 Union Ave. Bronx, N.Y.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed chest</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Infant thrown from car involved in a two car collision.</u>	
20c. TIME OF INJURY Month, Day, Year <u>1.18 AM 9-29-56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Salisbury Wicomico Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>9-29-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-3-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chapel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Columbia M. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R. Wilson</u>		24a. REC'D BY REGISTRAR <u>Mary W. Holloman</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>10-2-56</u>	

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10801

Item 18 Film G207 11-27-56 ams

9803

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>3 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Deal Island</u>		TOWN <u>18X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hosp.</u>				STREET ADDRESS (If rural give location) <u>Maria Road</u>			
3. NAME OF DECEASED (Type or Print) <u>BEULAH W. MOSTELLER</u>				4. DATE OF DEATH (Month) <u>Sept</u> (Day) <u>23</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWER, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 13 - 1885</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Household</u>		11. BIRTHPLACE (State or foreign country) <u>Deal Island Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SAMUEL WHITE</u>				14. MOTHER'S MAIDEN NAME <u>INDIANA WEBSTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>HARVEY MOSTELLER Deal Island</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
082X IMMEDIATE CAUSE (A) <u>Acute Equine encephalitis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-20</u> , 19 <u>56</u> , to <u>9-23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9-23</u> , 19 <u>56</u> , and that death occurred at <u>8 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Willen R. Ellis, Jr.</u>		M.D. <u>Salisbury, Md.</u>		DATE SIGNED <u>9-24-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept 26-56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Johns M.E. Cemetery</u>		LOCATION (City, town, or county) (State) <u>Deal Island Md.</u>	
24. REC'D BY REGISTRAR DATE <u>9/25/56</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>L. Webster</u>		ADDRESS <u>Deal Island Md.</u>	

CERTIFICATE OF DEATH

11-10-1956

11-10-1956

11-10-1956

*Late due to cert. being sent to Helene Sept.
10/19/56 - MB.*

BUREAU A. B.

OCT 19 1956

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9804

CERTIFICATE OF DEATH

89788

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>17 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville, Md.</u>				178-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>Liberty Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Justin</u> Middle <u>Boardman</u> Last <u>Powell</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>1st</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 20, 1880</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>		IF UNDER 24 HRS. Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>			
11. BIRTHPLACE (State or foreign country) <u>Macon, Georgia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Harney Twiggs Powell</u>				14. MOTHER'S MAIDEN NAME <u>Juliet Morgan Boardman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u> (If yes, give war or dates of service) <u>---</u>				16. SOCIAL SECURITY NO. <u>---</u>			
17. INFORMANT <u>Deer's Head Hospital Records, Salisbury, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial insufficiency</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>---</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>August 15, 19 56</u> , to <u>Sept. 1st, 19 56</u> , that I last saw the deceased alive on <u>Sept. 1, 19 56</u> , and that death occurred at <u>2:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. V. Maldve</u>				ADDRESS (Street, city or town, state) <u>Deer's Head Hospital, Salisbury, Md.</u>			
M.D. <u>L. V. Maldve, M. D.</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Sept. 4, 1956</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Chestfield Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Centreville Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>James W. Butler Jr. for Butler Bros.</u>				ADDRESS <u>Centreville, MD.</u>			
24a. REC'D BY REGISTRAR <u>SEP 10 1956</u>				24b. REGISTRAR'S SIGNATURE <u>Mary T. Holloway</u>			

CERTIFICATE OF DEATH

18

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY AND COUNTY	
OCCUPATION		CAUSE OF DEATH	
SEX		AGE	
RACE		RELIGION	
MARRIAGE		EDUCATION	
BIRTH		DEATH	
FATHER		MOTHER	
SPOUSE		CHILDREN	
PREVIOUS ILLNESS		MEDICAL ATTENDANCE	
BURIAL		INTERVIEW	
SIGNATURE OF REGISTRAR		DATE	

BUREAU V. S.

SEP 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9805

CERTIFICATE OF DEATH

09789

Reg. Dist. No.

334

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 3 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First John Middle Raymond Last Scott				4. DATE OF DEATH Month Sept. Day 14 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8/15/1890	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 66		IF UNDER 24 HRS. Days 66 Hours 66 Min. 66			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman & Engineer				10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Risdon Scott				14. MOTHER'S MAIDEN NAME Nancy Ann Diamond			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.				16. SOCIAL SECURITY NO. 218-208812		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis 153X DUE TO (b) Carcinoma of sigmoid Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes mellitus				INTERVAL BETWEEN ONSET AND DEATH 16 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Salisbury				20g. (County) Talbot		20h. (State) Maryland	
21. I certify that I attended the deceased from June 18 , 19 56 , to Sept. 14 , 19 56 , that I last saw the deceased alive on Sept. 14 , 19 56 , and that death occurred at 3 A. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Andres Grisolia M.D.				ADDRESS (Street, city or town, state) Deer's Head State Hospital			
PHYSICIAN'S NAME (Type) Andres Grisolia, M. D.				DATE SIGNED 9/14/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF SEPT. 17 1956		22c. NAME OF CEMETERY OR CREMATORY SPRING HILL CEM.	
22d. LOCATION (City, town, or county) Easton				22e. (State) M.D.			
23. FUNERAL DIRECTOR'S SIGNATURE W. Hampton Gwinn				ADDRESS Easton, M.D.		24a. REC'D BY REGISTRAR 18 1956	
24b. REGISTRAR'S SIGNATURE Mary K. Holloway							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V. S.

SEP 18 1956

RECEIVED

9806

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>9 N. Division Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SARAH HICKLING SHOWELL</u>		4. DATE OF DEATH Month Day Year <u>September 14 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 24, 1896</u>
9. AGE (In years lost birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DR. D PERCY HICKLING</u>		14. MOTHER'S MAIDEN NAME <u>HARRIET STONG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT Address <u>MR. S. DALE SHOWELL OCEAN CITY MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> <u>153X</u> DUE TO <u>Carcinoma of Calcium</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>18 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8:30</u> , 19 <u>56</u> , to <u>9:14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9:14</u> , 19 <u>56</u> , and that death occurred at <u>9:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. Brule</u>		DATE SIGNED <u>9/14/56</u>	
PHYSICIAN'S NAME (Type) <u>HENRY A. Baiele</u>		ADDRESS (Street, city or town, state) <u>Medical Center</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/16/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAUL'S CHURCHYARD</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donna A. Burdoye</u>		ADDRESS <u>Berlin Md</u>	
24a. REC'D BY REGISTRAR <u>SEP 17 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9807

CERTIFICATE OF DEATH

09791

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS 709 E. Isabella St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARION Middle FRANCIS Last SIMMS		4. DATE OF DEATH Month SEPT. Day 5 th Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 13, 1887
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 7 Days 12 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing		10b. KIND OF BUSINESS OR INDUSTRY Plumber	
11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Francis Simms		14. MOTHER'S MAIDEN NAME Mary M. Dykes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. 214-32-7008	
17. INFORMANT Mr. Thomas N. Simms R.D. # 1 Salisbury, Md.		Address Mr. John F. Simms (Father) Isabella St-Salisbury	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arteriosclerotic Disease 422.1 DUE TO Arteriosclerotic C-V Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH ?		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 4, 1956 , to Sept 5, 1956 , that I last saw the deceased alive on Sept 4, 1956 , and that death occurred at 8 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Camden Ave. (Office) Sept 6, 1956 DATE SIGNED Sept 6, 1956			
ACTUAL SIGNATURE William D. Gray M.D.			
PHYSICIAN'S NAME (Type) Dr. William D. Gray M.D. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 7, 1956	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME--SALISBURY, MD.			
24a. REC'D BY REGISTRAR SEP 10 1956		24b. REGISTRAR'S SIGNATURE May J. Holloway	

10

— — —

... ..

BUREAU V. S.

SEP 10 1956

RECEIVED

1
12
91
10
0
1
BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09792

9808

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland		c. LENGTH OF STAY IN 1b 2 yr. 5 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston, Maryland 05x-2	
4. DATE OF DEATH Month Sept. Day 14 Year 1956		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elsie Middle Spence		4. DATE OF DEATH Month Sept. Day 14 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1879
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel R. Buckley		14. MOTHER'S MAIDEN NAME Charlotte Wright	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 217-05-3761	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus 421.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease with Aortic Stenosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 12 , 19 54 , to Sept. 14 , 19 56 , that I last saw the deceased alive on Sept. 14 , 19 56 , and that death occurred at 4:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE V. Juerman		DATE SIGNED 9/15/56	
PHYSICIAN'S NAME (Type) V. Juerman, M.D.		ADDRESS Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9/17/1956	
22c. NAME OF CEMETERY OR CREMATORY Choptank Cemetery		22d. LOCATION (City, town, or county) (State) near Preston, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry Williams		ADDRESS Federalsburg, Md.	
24a. REC'D BY REGISTRAR DATE 9-21-56		24b. REGISTRAR'S SIGNATURE Mary W. Holloman	

CERTIFICATE OF DEATH

MAINE STATE DEPARTMENT OF HEALTH - BANGOR, ME

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible] DATE OF BIRTH: [illegible]

RESIDENCE: [illegible] OCCUPATION: [illegible] CAUSE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible] SIGNATURE OF PHYSICIAN: [illegible]

SIGNATURE OF REGISTRAR: [illegible] OFFICIAL SEAL: [illegible]

DATE OF REGISTRATION: [illegible] PLACE OF REGISTRATION: [illegible]

REMARKS: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

REMARKS: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

REMARKS: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

REMARKS: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

REMARKS: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

REMARKS: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

REMARKS: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

REMARKS: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

REMARKS: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

REMARKS: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

BUREAU V. S.

SEP 24 1956

RECEIVED

9809

CERTIFICATE OF DEATH

09793 337
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lucie</u> Middle <u>MARIE</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 25, 1895</u>	9. AGE (in years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Musician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Music</u>		11. BIRTHPLACE (State or foreign country) <u>Fruitland Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>James S. Taylot</u>				14. MOTHER'S MAIDEN NAME <u>Ella H. Bradley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mr James S. Taylor (Father)</u> Address <u>306 Maryland Ave. Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulm. Tbc</u> 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last: (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/14</u> , 19 <u>56</u> , to <u>9/16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/14</u> , 19 <u>56</u> , and that death occurred at <u>8:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>Sept. 16, 1956</u>							
ACTUAL SIGNATURE <u>Dr. Fred R. Gramse</u> M.D.				PHYSICIAN'S NAME (Type) <u>Dr. Fred R. Gramse</u> M.D. <u>S. Division St. Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 19, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.</u> ADDRESS <u></u>				24a. REC'D BY REGISTRAR <u>SEP 18 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 18 1956

RECEIVED

9810

CERTIFICATE OF DEATH

Reg. Dist. No.

09794

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>18 months</u>			
d. NAME OF HOSPITAL (If in hospital, give street address) OR INSTITUTION <u>Shing Hill Cottage Sanatorium</u>				d. STREET ADDRESS <u>Snow Hill</u>			
3. NAME OF DECEASED (Type or print) <u>Lillie</u> First <u>Maurence</u> Middle <u>Lilghman</u> Last				4. DATE OF DEATH <u>Sept</u> Month <u>16</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1 - 1876</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 2 YRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Whaleyville, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert Henry Davis</u>				14. MOTHER'S MAIDEN NAME <u>Ethel Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Elsie J. Moore</u> Address <u>Snow Hill, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Pulmonary Disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept. 16</u> 19 <u>56</u> to <u>Sept. 16</u> 19 <u>56</u> , that I last saw the deceased alive on <u>Sept. 16</u> 19 <u>56</u> , and that death occurred at <u>4 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip A. Insley</u> M.D.				ADDRESS (Street, city or town, state) <u>116 E. MAIN ST.</u> DATE SIGNED <u>9/18/56</u>			
PHYSICIAN'S NAME (Type) <u>Philip A. Insley</u>				<u>Salisbury Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Sept. 19/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shing Hill</u>	
22d. LOCATION (City, town, or county) <u>Snow Hill</u>				(State) <u>md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton J. Smith</u>				ADDRESS <u>Snow Hill, md</u>		24a. REC'D BY REGISTRAR <u>SEP 19 1956</u>	
						24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3.

67 1956

RECEIVED

9815

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Curfew</u> Middle <u>Wallace</u> Last				4. DATE OF DEATH Month <u>Sept.</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/10/1895</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u>3</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oysterman</u>		11. BIRTHPLACE (State or foreign country) <u>Nanticoke, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Lssac Wallace</u>				14. MOTHER'S MAIDEN NAME <u>Mary Nutter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>World War 1</u>		17. INFORMANT <u>Olivia Bradshaw, Nanticoke, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6 Nov. 1948</u> to <u>13 Sept. 1956</u> that I last saw the deceased alive on <u>13 Sept. 1956</u> , and that death occurred at <u>5 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D.				ADDRESS (Street, city or town, state) <u>Nanticoke Md</u>			
DATE SIGNED <u>9/14/56</u>							
PHYSICIAN'S NAME (Type) <u>Richard H. Saunders</u>				<u>Nanticoke, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/16/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nanticoke Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Nanticoke, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Mearick</u>				ADDRESS <u>Bivalve, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE 26 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1955 33 455

RECEIVED

9816

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela				c. LENGTH OF STAY IN 1b 26 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD # 1				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Watson Last Watson				4. DATE OF DEATH Month Sept. Day 16 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 26, 1878	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Scotland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James Watson				14. MOTHER'S MAIDEN NAME Mary Kidd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Helen Watson, Mardela, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute pulmonary edema DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertrophy of prostate gland with some retention INTERVAL BETWEEN ONSET AND DEATH 4 hrs 2							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 18, 1956 , to Sept 16, 1956 , that I last saw the deceased alive on Sept 18, 1956 , and that death occurred at 7:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				DATE SIGNED Sept 17, 1956			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-18-56		22c. NAME OF CEMETERY OR CREMATORY Mardela		22d. LOCATION (City, town, or county) (State) Mardela, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles M. Mardel				24a. REC'D BY REGISTRAR [Signature]		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 332									
1. PLACE OF DEATH o. COUNTY Worcester					2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) o. STATE Maryland b. COUNTY Worcester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital					d. STREET ADDRESS R F D # 2				
3. NAME OF DECEASED (Type or print) Baby Boy White					4. DATE OF DEATH Month 9 Day 17 Year 19 56				
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-17-56		9. AGE (In years last birthday) yrs. Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (State or foreign country) Berlin, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John H. White					14. MOTHER'S MAIDEN NAME Esther Fooks				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address John H. White-father- Berlin, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from cord 926.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 8 hours.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Cord tie loose						
20c. TIME OF INJURY Month, Day, Year Hour 8 o. m. 9-17 1956			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Berlin		(County) Worcester (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE Earl L. Royer					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) Earl L. Royer					DATE SIGNED 9-18-56				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 9-18-56		22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Berlin, Worcester Co., Md.		
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.					24a. REC'D BY REGISTRAR DATE SEP 19 1956		24b. REGISTRAR'S SIGNATURE Mary Holloway		

1000286XV6

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF DEATH REGISTRAR		18. SIGNATURE OF CLERK	
19. SIGNATURE OF CHIEF OF POLICE		20. SIGNATURE OF SHERIFF		21. SIGNATURE OF JAILER	
22. SIGNATURE OF PRISON WARDEN		23. SIGNATURE OF COURT CLERK		24. SIGNATURE OF JUDGE	
25. SIGNATURE OF DISTRICT ATTORNEY		26. SIGNATURE OF COUNTY ATTORNEY		27. SIGNATURE OF CITY ATTORNEY	
28. SIGNATURE OF TOWN ATTORNEY		29. SIGNATURE OF VILLAGE ATTORNEY		30. SIGNATURE OF PARISH ATTORNEY	
31. SIGNATURE OF CHURCH WARDEN		32. SIGNATURE OF CHURCH CLERG		33. SIGNATURE OF CHURCH MEMBERS	
34. SIGNATURE OF CHURCH DEACONS		35. SIGNATURE OF CHURCH ELDER		36. SIGNATURE OF CHURCH MODERATOR	
37. SIGNATURE OF CHURCH TREASURER		38. SIGNATURE OF CHURCH SECRETARY		39. SIGNATURE OF CHURCH CHORUS	
40. SIGNATURE OF CHURCH BAND		41. SIGNATURE OF CHURCH SINGERS		42. SIGNATURE OF CHURCH PRAYER LEADERS	
43. SIGNATURE OF CHURCH SUNDAY SCHOOL		44. SIGNATURE OF CHURCH YOUTH GROUP		45. SIGNATURE OF CHURCH ADULT EDUCATION	
46. SIGNATURE OF CHURCH COUNCIL		47. SIGNATURE OF CHURCH COMMITTEE		48. SIGNATURE OF CHURCH BOARD	
49. SIGNATURE OF CHURCH SYNOD		50. SIGNATURE OF CHURCH CONFERENCE		51. SIGNATURE OF CHURCH GENERAL ASSEMBLY	
52. SIGNATURE OF CHURCH ANNUAL MEETING		53. SIGNATURE OF CHURCH SPECIAL MEETING		54. SIGNATURE OF CHURCH EMERGENCY MEETING	
55. SIGNATURE OF CHURCH AD-HOC COMMITTEE		56. SIGNATURE OF CHURCH TASK FORCE		57. SIGNATURE OF CHURCH WORKING GROUP	
58. SIGNATURE OF CHURCH STUDY GROUP		59. SIGNATURE OF CHURCH RESEARCH GROUP		60. SIGNATURE OF CHURCH EVALUATION GROUP	
61. SIGNATURE OF CHURCH PLANNING GROUP		62. SIGNATURE OF CHURCH IMPLEMENTATION GROUP		63. SIGNATURE OF CHURCH MONITORING GROUP	
64. SIGNATURE OF CHURCH REPORTING GROUP		65. SIGNATURE OF CHURCH FOLLOW-UP GROUP		66. SIGNATURE OF CHURCH EVALUATION GROUP	
67. SIGNATURE OF CHURCH REVISION GROUP		68. SIGNATURE OF CHURCH RE-EVALUATION GROUP		69. SIGNATURE OF CHURCH RE-IMPLEMENTATION GROUP	
70. SIGNATURE OF CHURCH RE-MONITORING GROUP		71. SIGNATURE OF CHURCH RE-REPORTING GROUP		72. SIGNATURE OF CHURCH RE-FOLLOW-UP GROUP	
73. SIGNATURE OF CHURCH RE-EVALUATION GROUP		74. SIGNATURE OF CHURCH RE-IMPLEMENTATION GROUP		75. SIGNATURE OF CHURCH RE-MONITORING GROUP	
76. SIGNATURE OF CHURCH RE-REPORTING GROUP		77. SIGNATURE OF CHURCH RE-FOLLOW-UP GROUP		78. SIGNATURE OF CHURCH RE-EVALUATION GROUP	
79. SIGNATURE OF CHURCH RE-IMPLEMENTATION GROUP		80. SIGNATURE OF CHURCH RE-MONITORING GROUP		81. SIGNATURE OF CHURCH RE-REPORTING GROUP	
82. SIGNATURE OF CHURCH RE-FOLLOW-UP GROUP		83. SIGNATURE OF CHURCH RE-EVALUATION GROUP		84. SIGNATURE OF CHURCH RE-IMPLEMENTATION GROUP	
85. SIGNATURE OF CHURCH RE-MONITORING GROUP		86. SIGNATURE OF CHURCH RE-REPORTING GROUP		87. SIGNATURE OF CHURCH RE-FOLLOW-UP GROUP	
88. SIGNATURE OF CHURCH RE-EVALUATION GROUP		89. SIGNATURE OF CHURCH RE-IMPLEMENTATION GROUP		90. SIGNATURE OF CHURCH RE-MONITORING GROUP	
91. SIGNATURE OF CHURCH RE-REPORTING GROUP		92. SIGNATURE OF CHURCH RE-FOLLOW-UP GROUP		93. SIGNATURE OF CHURCH RE-EVALUATION GROUP	
94. SIGNATURE OF CHURCH RE-IMPLEMENTATION GROUP		95. SIGNATURE OF CHURCH RE-MONITORING GROUP		96. SIGNATURE OF CHURCH RE-REPORTING GROUP	
97. SIGNATURE OF CHURCH RE-FOLLOW-UP GROUP		98. SIGNATURE OF CHURCH RE-EVALUATION GROUP		99. SIGNATURE OF CHURCH RE-IMPLEMENTATION GROUP	
100. SIGNATURE OF CHURCH RE-MONITORING GROUP		101. SIGNATURE OF CHURCH RE-REPORTING GROUP		102. SIGNATURE OF CHURCH RE-FOLLOW-UP GROUP	

BUREAU V. S.

SEP 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9812 CERTIFICATE OF DEATH

89798

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 619 E. Church St				d. STREET ADDRESS 619 East Church St			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CARL Middle PRETTYMAN Last WILKINS				4. DATE OF DEATH Month Sept. Day 24th Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1887		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months 6 Days 16	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee of the City of Salisbury (Street Dept)				10b. KIND OF BUSINESS OR INDUSTRY Parsonsborg, Maryland		11. BIRTHPLACE (State or foreign country) U S A	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Isaac Wilkigs				14. MOTHER'S MAIDEN NAME Lavenia Calloway			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 			
17. INFORMANT Mrs. Elizabeth Wilkins (Wife)				Address 619 Church St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma 7th lung. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 1 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Degenerative heart disease.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 54 , to Sept 24 56 , that I last saw the deceased alive on Sept 24 56 , and that death occurred at 10:45 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Carl M. Beardsley				ADDRESS (Street, city or town, state) 207 Maryland Ave. (Office) Sept 26, 1956			
DATE SIGNED Sept 26, 1956							
PHYSICIAN'S NAME (Type) Dr. E.M. Beardsley				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 27, 1956		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR SEP 28 1956		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		67		Male		White		1888		Maryland	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1000 North Howard St.		Retired		Heart Disease		Natural		Sept 28, 1956		Baltimore, Md.	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		RELIGION	
JAMES H. HARRIS		MARY H. HARRIS		JANE H. HARRIS		JOHN H. HARRIS		High School		Roman Catholic	
PREVIOUS ILLNESS		TREATMENT		HISTORY		LABORATORY		X-RAY		PATHOLOGICAL	
None		None		None		None		None		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

BUREAU V. 2

SEP 28 1956

RECEIVED